NOTICE OF COMPLETED INTAKE

FOR REFERRALS FROM DMH

(This form is to be completed by the service coordinator on those individuals referred by the SCDMH after a determination regarding eligibility has been made.)

NAME:

DOB: __ COUNTY/REGION: _____/_____ SEX: ___

PREVIOUS DSN CLIENT: _____YES _____NO _____IN QUESTION

FSIQ ___ ADAPTIVE ____ TESTING DATE TEST USED ____

HOME ADDRESS: _____

_____

CURRENT PLACEMENT: _____

_____

CLIENT SERVICE NEEDS FROM DSN (from E&P staffing summary)

_____

_____

CURRENT PSYCHIATRIC DIAGNOSIS:

_____

CURRENT SERVICE NEEDS FROM DMH:

OTHER SERVICE NEEDS:

ADDITIONAL INFORMATION:

DATE OF LAST ADMISSION TO DMH: _____

DATE OF DISCHARGE: (if discharged) _____

SERVICE COORDINATOR ASSIGNED: _____

DATE: _____

cc: **Director of Service Coordination**

Interagency Liaison for DMH/DDSN Print This Form **August 17, 1995**